

William D. Stewart, D.M.D., P.A.

1327 Drayton Road
Spartanburg, South Carolina 29307

Welcome to our office and thank you for choosing our office for your dental needs. We ask that you complete the following information so that we can offer you the best treatment possible.

Today's Date _____

PLEASE PRINT

PATIENT INFORMATION				EMPLOYER INFORMATION	
Name <small>First Middle Last</small>				Occupation	
Nickname				Employer	
SSN				Street Address	
Home Address				Mailing Address	
Mailing Address				City, State & Zip Code	
City, State & Zip Code				Work Phone# ext.	
Home Phone #					
Date of Birth <small>Month Day Year</small>				EMERGENCY CONTACT (Not in the same household)	
Sex: M F Marital Status: S M D W				Name	
Spouse's Name				Address	
				Phone#	

IF YOU ARE COMPLETING THIS FORM FOR ANOTHER PERSON, PLEASE PRINT YOUR NAME AND RELATIONSHIP TO THE PATIENT

Name _____

Relationship _____

Eaglesoft Medical History (with sleep apnea questions)

Patient Name:

Birth Date:

Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, c

Are you under a physician's care now? Have you ever been hospitalized or had a major operation? Have you ever had a serious head or neck injury? Are you taking any medications, pills, or drugs? Do you take, or have you taken, Phen-Fen or Redux? Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Are you on a special diet? Do you use tobacco? Do you use controlled substances?

Women: Are you...

Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic Metal Latex Sulfa Drugs Local Anesthetics

Other? If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive Alzheimer's Disease Anaphylaxis Anemia Angina Arthritis/Gout Artificial Heart Valve Artificial Joint Asthma Blood Disease Blood Transfusion Breathing Problems Bruise Easily Cancer Chemotherapy Chest Pains Cold Sores/Fever Blisters Congenital Heart Disorder Convulsions Yellow Jaundice Cortisone Medicine Diabetes Drug Addiction Easily Winded Emphysema Epilepsy or Seizures Excessive Bleeding Excessive Thirst Fainting Spells/Dizziness Frequent Cough Frequent Diarrhea Frequent Headaches Genital Herpes Glaucoma Hay Fever Heart Attack/Failure Heart Murmur Heart Pacemaker Heart Trouble/Disease Hemophilia Hepatitis A Hepatitis B or C Herpes High Blood Pressure High Cholesterol Hives or Rash Hypoglycemia Irregular Heartbeat Kidney Problems Leukemia Liver Disease Low Blood Pressure Lung Disease Mitral Valve Prolapse Osteoporosis Pain in Jaw Joints Parathyroid Disease Psychiatric Care Radiation Treatments Recent Weight Loss Renal Dialysis Rheumatic Fever Rheumatism Scarlet Fever Shingles Sickle Cell Disease Sinus Trouble Spina Bifida Stomach/Intestinal Disease Stroke Swelling of Limbs Thyroid Disease Tonsillitis Tuberculosis Tumors or Growths Ulcers Venereal Disease

Have you ever had any serious illness not listed above? Have you ever been diagnosed with Obstructive Sleep Apnea? Do you currently wear or have you been prescribed a CPAP or APAP machine for Sleep Apnea by your physician? Do you snore loudly or have you ever been told that you stop breathing during the middle of the night?

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian: X Date: